Minutes of the meeting of the Managed Care Committee of the Board of Directors of the Cook County Health and Hospitals System held Thursday, February 19, 2015 at the hour of 10:00 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Acting Chairman Velasquez called the meeting to order.

Present: Directors Emilie N. Junge and Carmen Velasquez (2)

Director Ada Mary Gugenheim

Present Telephonically: Chairman Wayne M. Lerner, DPH, LFACHE and Board Chairman M. Hill Hammock (ex-officio)

Absent: None (0)

Director Junge, seconded by Acting Chairman Velasquez, moved to allow Chairman Lerner and Board Chairman Hammock to participate in the meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Chairman Lerner resumed the Chair and the meeting proceeded.

Additional attendees and/or presenters were:

Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
Doug Elwell – Deputy CEO of Strategy and Finance and Interim Deputy CEO of Operations
Steven Glass – Executive Director of Managed Care
Randolph Johnston – System Associate General Counsel
Elizabeth Reidy – General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD –Chief Executive Officer

II. Public Speakers

Chairman Lerner asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report on CountyCare Health Plan (Attachment #1)

A. Metrics
B. Redetermination Process
C. Report from Corporate Compliance

Steven Glass, Executive Director of Managed Care, reviewed the Report on the CountyCare Health Plan. Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, reviewed the information in the presentation relating to Corporate Compliance (Fraud, Waste and Abuse, and Grievances and Appeals). The Committee reviewed and discussed the information.

III. Report on CountyCare Health Plan (continued)

During the discussion of the data regarding membership on slide 4, Mr. Glass provided information explaining why membership is lower than what was budgeted. He indicated that the implementation of the choice process for the Family Health Plan (FHP) population was delayed; the State was under a plan to start implementing the choice process for FHP members in July - it actually got implemented in September, so CCHHS is a little bit behind budget simply because the State was behind. The Committee should see a catch-up to the projected budget numbers sometime around May. It was noted that the membership figure of 124,000 is specific to the budgeted number of members for the month of December; Board Chairman Hammock suggested that the heading for that data reflect that information, so it is clearer that the number is not one fixed projection for the year.

Chairman Lerner stated that, perhaps for the next meeting, which will have a deeper drill-down on Managed Care, the presentation could have a slide on a going-forward basis that lays out the direction of membership and how that compares to the budget comparisons.

During the review of the information on slide 5, regarding membership comparisons, the Committee discussed the differences in net member change between CountyCare and the two larger plans listed; under the "fair share" distribution that is supposed to take place with auto-assignments, it was not clear how CountyCare could have a net decrease while the two larger plans enjoyed significant increases in members for the month of December. Additionally, it was noted that the two larger plans had been suspended from receiving new members through auto-assignment for a short time, but the suspensions were recently lifted; Mr. Glass noted that the impact of the suspensions that occurred in December would likely not be seen until February. He stated that the administration is actively working to address the issue and resolve the question relating to the December membership comparison. Board Chairman Hammock encouraged the administration to escalate this issue to the highest levels to reach the answer.

In response to the question regarding whether the administration has met with the individuals representing the new administration at the State, Dr. John Jay Shannon, Chief Executive Officer, stated that there is a meeting planned in March; he noted that there has been significant focus on not only the transition relating to the administration but also on the State's budget. Chairman Lerner suggested that this subject be placed on the agenda for the March Managed Care Committee Meeting and Board Meeting.

With regard to the information on slide 7, Board Chairman Hammock inquired whether the Plan can dictate that members only use the CCHHS pharmacy; additionally, he inquired whether the Plan can require that members pay a co-pay if they do not use the CCHHS pharmacy. Mr. Glass responded that both are options that are available. He noted that, in the upcoming months, there will come a time when it is no longer voluntary; rather; the Plan will deny any kind of prescription fill for these medications at any pharmacy other than CCHHS' pharmacy. With regard to co-pays, to date, Mr. Glass stated that the administration has taken the position of not having any co-pays for services; that was established under the Waiver. He added that it is certainly a strategic question that could be explored. He was unsure about the limits of the amount that can be charged for co-pays; he stated that it may be limited to the Medicaid level of co-pays, which he believes is $3.00 per prescription.

Mr. Glass stated that the administration has informed leadership at the Ruth M. Rothstein CORE Center of Cook County that members have another 60 days maximum before the mandate regarding filling prescriptions at the CCHHS pharmacy kicks in. He noted that care needs to be taken to avoid any potential disruption of care or gap in receiving HIV medications for members. Chairman Lerner stated that, for the March Board Meeting, the measures regarding HIV patient medications and mail order medications on slide 7 should be included in the drill-down. Additionally, Director Junge requested that information on possible reasons why members are not using the CCHHS pharmacy be provided.

IV. Action Items

A. Minutes of the Managed Care Committee Meeting, January 22, 2015

Director Junge, seconded by Chairman Lerner, moved to accept the minutes of the meeting of the Managed Care Committee of January 22, 2015. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Section IV

V. Adjourn

As the agenda was exhausted, Chairman Lerner declared the meeting ADJOURNED.

Respectfully submitted,
Managed Care Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXX
Wayne M. Lerner, DPH, LFACHE, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

CountyCare Report

Prepared for: CCHHS Board Managed Care Committee

STEVEN GLASS, EXECUTIVE DIRECTOR, MANAGED CARE

FEBRUARY 19, 2015

Report Format

Metrics

1. Membership
2. Risk Management
3. Care Management
4. Operations

Programmatic

1. Choice & Redetermination

Changes to Reporting Metrics

Metric Category	Update(s)
All	Calculated "% Change From Month Prior" for all measures, not simple change in %
All	Added month-to-month trend indicator
Membership	None
Risk Management/Pharmacy	Added: • % Utilizing Members • # Scripts/Utilizer
Care Management/PCMH Assignment	Added: • % Members Unassigned • # Assigned CCHHS/ACHN • # Assigned MHN ACO
Operations/Claims Processing	Added: • # Claims Received/DOS

1) Membership

Data as of: 1/31/2015 | Source: Daily Membership (834) File

	Nov'14	Dec'14	Jan'15	Change From Dec'15	Trend	FY'15 Budget	% to Budget
Monthly Membership	85,085	86,562	96,508	11.5%	↑	124,318	77.6%
ACA	*82,496*	*78,914*	*79,901*	1.3%	↑	*85,628*	*93.3%*
FHP	*1,324*	*6,111*	*14,837*	142.8%	↑	*35,000*	*42.4%*
SPD	*1,038*	*1,537*	*1,770*	15.2%	↑	*3,690*	*48.0%*
Home/Community Waiver	*227*	*271*	*504*				
				Key:	Within 5% of Goal	5-10% of Goal	> 10% of Goal

Gender = 50% Female; 50% Male

Average age = Female: 41 y/o; Male: 39 y/o

FHP membership below budget due to State implementation delay

- Expected to catch-up in later months

ACA redeterminations continued to be suspended in January

1) Membership Comparison

Source: IL HFS, Cook & Metro Chicago Regions

FHP/ACA Adults

Health Plan	Oct'14		Nov'14		Dec'14		N Change Month Prior
	N	% Total	N	% Total	N	% Total	
Harmony Health Plan *	89,964	29.4%	107,840	29.2%	151,195	26.1%	43,355
Family Health Network *	111,073	36.3%	111,300	30.1%	123,966	21.4%	12,666
CountyCare	**88,858**	**29.1%**	**85,453**	**23.1%**	**83,733**	**14.5%**	**(1,720)**
Blue Cross Blue Shield	1,482	0.5%	7,977	2.2%	43,575	7.5%	35,598
Advocate Accountable Care (ACE)	7,597	2.5%	13,812	3.7%	34,495	6.0%	20,683
Meridian Health Plan	3,633	1.2%	14,195	3.8%	33,848	5.8%	19,653
IlliniCare Health Plan	1,578	0.5%	10,520	2.8%	31,944	5.5%	21,424
Aetna Better Health Inc.	523	0.2%	9,875	2.7%	22,848	3.9%	12,973
SmartPlan Choice (ACE)	32	0.0%	2,007	0.5%	17,661	3.0%	15,654
HealthCura (ACE) **	28	0.0%	181	0.0%	14,318	2.5%	14,137
Community Care Partners (ACE)	22	0.0%	302	0.1%	9,700	1.7%	9,398
Illinois Partnership for Health (ACE) **	298	0.1%	2,160	0.6%	3,731	0.6%	1,571
Loyola Family Care (ACE)	150	0.0%	1,665	0.5%	3,390	0.6%	1,725
MyCare Chicago (ACE)	478	0.2%	1,598	0.4%	1,937	0.3%	339
Better Health Network (ACE)	11	0.0%	155	0.0%	976	0.2%	821
Lurie Children's Health Partners (CSN CCE)	92	0.0%	414	0.1%	801	0.1%	387
UI Health Plus (ACE)	4	0.0%	39	0.0%	609	0.1%	570
Next Level (CCE serving ACA only)	41	0.0%	263	0.1%	434	0.1%	171
LaRabida Coordinated Care Network (CSN CCE)	4	0.0%	34	0.0%	92	0.0%	58
Total	**305,868**		**369,790**		**579,253**		**209,463**

** = Auto-assignment suspended due to poor quality measures*

*** = Auto-assignment suspended for failure to meet ACE benchmarks*

1) Membership Comparison

Source: IL HFS, Cook & Metro Chicago Regions

ICP Greater Chicago Region (SPD population)

Health Plan	Oct'14		Nov'14		Dec'14		N Change Month Prior
	N	% Total	N	% Total	N	% Total	
Aetna Better Health Inc.	28,547	32.2%	29,377	31.2%	29,180	31.0%	(197)
IlliniCare Health Plan Inc.	28,018	31.6%	28,422	30.2%	28,067	29.8%	(355)
Humana Health Plan	3,679	4.2%	4,162	4.4%	4,603	4.9%	441
Meridian Health Plan	4,164	4.7%	4,059	4.3%	4,188	4.5%	129
Blue Cross/Blue Shield of Illinois	4,610	5.2%	5,422	5.8%	5,597	6.0%	175
Cigna HealthSpring of Illinois	3,193	3.6%	4,143	4.4%	4,142	4.4%	(1)
Community Care Alliance of Illinois	6,954	7.8%	7,726	8.2%	7,766	8.3%	40
CountyCare	**352**	**0.4%**	**1,169**	**1.2%**	**1,535**	**1.6%**	**366**
Be Well (CCE)	1,450	1.6%	1,396	1.5%	1,374	1.5%	(22)
EntireCare (CCE)	2,169	2.4%	2,211	2.3%	2,179	2.3%	(32)
Together4Health (CCE)	1,521	1.7%	1,530	1.6%	1,582	1.7%	52
Next Level (CCE)	3,987	4.5%	4,616	4.9%	3,826	4.1%	(790)
Total	**88,644**		**94,233**		**94,039**		**(194)**

2) Risk Management

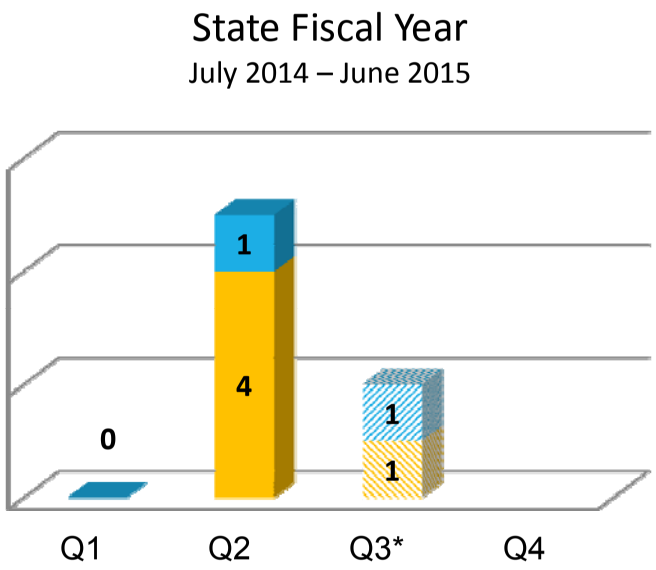
Key Measures	Dec'14	Jan'15	% Change From Month Prior	Trend	Target/ Comparison	% to Target/ Comparison
Risk Management						
						Mar'14 to Dec'14 Shift
ACA Adult Membership						
% 19-24 y/o	16.4%	16.2%	-1.2%	↓	17.0%	-0.8%
% 25-34 y/o	15.2%	15.5%	2.0%	↑	14.8%	0.7%
% 35-44 y/o	13.2%	13.3%	0.8%	↑	13.5%	-0.2%
% 45-54 y/o	26.2%	26.2%	0.0%	--	27.6%	-1.4%
% 55+ y/o	29.1%	28.9%	-0.7%	↓	27.0%	1.9%
Pharmacy						
# Scripts filled	131,086	134,787	2.8%			
% Utilizing Members ***NEW***	40%	37%	-6.1%			
# Scripts/Utilizer ***NEW***	3.81	3.75	-1.6%			
% Generic dispensing	83%	84%	0.4%			
% Brand Single Source	16%	16%	0.0%			
% Formulary	98%	98%	0.0%		98%	0.0%
% CCHHS HIV pt meds @ CCHHS pharmacy	18.5%	25.1%	35.7%		80%	-54.9%
% Mail order meds @ CCHHS pharmacies	5.1%	5.1%	0.0%		20%	-14.9%
Reinsurance						
# Claims filed	0	0	0.0%			

Fraud, Waste and Abuse Program

The Program,

- Monitors the Health Plan's Fraud, Waste and Abuse (FWA) Program with goal of protecting consumers in the delivery of healthcare services through timely detection, investigation and prosecution of FWA.
- Achieves goal by establishing:
  - Training programs for CountyCare employees, vendors, subcontractors, about their role in the FWA process.
  - Defining methods to identify, prevent, review and initiate corrective actions against any provider or member who is suspected of participating in FWA activities.
  - Developing policies and procedures.
  - Outlining the workflow to be followed in the event that a potential FWA issue or overpayment is identified.
  - Reporting identified FWA issues, including referral to state and local authorities.
- Oversees all FWA activities performed by Health Plan's delegated vendors.

FWA Activity



Q3* = only 1-month of data (January)

- HFS requirements
  - Quarterly reporting

Seven (7) cases identified to date:

- Four (4) Providers
  - Potential upcoding on two (2)
  - Potential "boiler plate" coding on one (1)
  - One (1) provider misidentified as CountyCare (case closed)
- Two (2) Ambulance Providers
  - Potential upcoding
- One (1) Member
  - Allegation of ineligibility (transitioned to HFS OIG – closed)

Grievances and Appeals

The Process,

- Provides a mechanism for members to file complaints and a way for members or providers to file appeals when a request for a medical item or service is denied by CountyCare.
- Allows for tracking of grievances and appeals by category, volume and resolution.
- Contributes to identify program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.
- Represents a primary mechanism for CCHHS Corporate Compliance and CountyCare operations to exercise oversight of the Third Party Administrator (TPA) and other vendor operations with respect to grievances and appeals.

DEFINITIONS GRIEVANCES AND APPEALS

Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of as defined below. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. The report shall include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved and whether the appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services. ***Reporting Frequency: Quarterly***

Section	Term	Definition
Types	**Grievance**	The expression of dissatisfaction by a Member including complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an appeal.
	Appeal	A request for review of a decision made by CountyCare with respect to an action. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure to act within the set timeframes.
	Expedited Appeal	An appeal filed when taking the time for a standard (appeal) resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function.
	External Independent Review	Except for denial or Waiver services, which may not be reviewed by an external independent entity, the Enrollee may request an external independent review, both standard and expedited timeframes, of appeals that are denied by Contractor within thirty (30) calendar days after the date of the Contractor's decision notice [HFS].
	Fair Hearing	The State plan must provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its Fair Hearings system within thirty (30) calendar days after the date of the Contractor's Decision Notice.
Section	**Term**	**Definition**
Categories	**Medical Necessity**	Determinations on decisions that are or which could be considered covered benefits. This includes determinations for covered medical benefits as defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits and care of service that could be considered either covered or non-covered, depending on the circumstances.
	Access to Care	Areas of concerns such as: cannot find Provider, inconvenient hours, Provider capacity, out of area Providers, refusal to take Medicaid, ADA non-compliance, unable to address language needs, not meeting appointment times requirements.
	Quality of Care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
	Transportation	Any grievance or appeal relating to the transportation benefits.
	Pharmacy	Any grievance or appeal relating to the pharmacy benefits.
	HCBS Waiver Services	*Grievance:* Any expression of dissatisfaction relating to HCBS Waiver Services. *Appeal:* Any appeal related to the reduction, elimination, or timeliness of services or hours through the Community Care Program or the Home Services Program.
	Long Term Care (LTC) Services	*Grievance:* Any expression of dissatisfaction relating to LTC Services. *Appeal:* Any appeal related to the reduction, elimination, or timeliness of services or hours through the Community Care Program or the Home Services Program.
	Other	Any kind of grievance or appeal not covered by the previously mentioned topics.

GRIEVANCE AND APPEALS SUMMARY
July 2014 – September 2014
Q1 , SFY 2015

Grievances and Appeals Received

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	12	41	1	1	-	-	1	56
Appeals	-	-	-	-	4	-	-	-	4
Expedited Appeals	-	-	-	-	-	-	-	-	-
Total	-	12	41	1	5	-	-	1	60

Grievances and Appeals Resolved

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	9	39	-	-	-	-	-	48
Appeals	-	-	-	-	2	-	-	-	2
Expedited Appeals	-	-	-	-	16	-	-	-	-
Total	-	-	39	-	18	-	-	-	50

Grievances Outcomes

Category	Total # of Grievances Resolved	# of Grievances Resolved within 90 Days	% of Grievances Resolved within 90 Days
Grievances Resolved	48	48	100%

Appeals Outcomes

Category	Upheld	Overturned	# of Appeals Resolved within 15 Business Days	% of Appeals Resolved within 15 Business Days
Appeals Upheld/Overturned at MCO Level	1	1	2	100%
Total	1	1		

Expedited Appeals Outcomes

Category	Upheld	Overturned	# of Expedited Appeals Resolved within 24 Hours	% of Expedited Appeals Resolved within 24 Hours
Expedited Appeals Upheld/Overturned at MCO Level	-	-	-	N/A
Total	-	-		

GRIEVANCE AND APPEALS SUMMARY
October 2014 - December 2014
Q2 , SFY 2015

Grievances and Appeals Received

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	4	33	5	-	-	-	13	55
Appeals	15	-	-	-	32	-	-	-	47
Expedited Appeals	-	-	-	-	16	-	-	-	16
Total	15	4	33	5	48	-	-	13	118

Grievances and Appeals Resolved

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	3	10	-	-	-	-	5	18
Appeals	10	-	-	-	29	-	-	-	39
Expedited Appeals	-	-	-	-	16	-	-	-	16
Total	10	3	10	-	45	-	-	5	73

Grievances Outcomes

Category	Total # of Grievances Resolved	# of Grievances Resolved within 90 Days	% of Grievances Resolved within 90 Days
Grievances Resolved	18	18	100%

Appeals Outcomes

Category	Upheld	Overturned	# of Appeals Resolved within 15 Business Days	% of Appeals Resolved within 15 Business Days
Appeals Upheld/Overturned at MCO Level	-	10	10	100%
Total	-	10		

Expedited Appeals Outcomes

Category	Upheld	Overturned	# of Expedited Appeals Resolved within 24 Hours	% of Expedited Appeals Resolved within 24 Hours
Expedited Appeals Upheld/Overturned at MCO Level	3	13	7	43.75%
Total	3	13		

3) Care Management

Key Measures	Dec'14	Jan'15	% Change From Month Prior	Trend	Target/ Comparison	% to Target/ Comparison
Care Management						
PCMH Assignment						
Total Membership	86,562	96,618	11.6%	↑	124,318	77.7%
% Members Unassigned ***NEW***	0.8%	0.9%	7.3%	↓		
# Assigned CCHHS/ACHN ***NEW***	26,276	27,902	6.2%	↑		
% Total Members @ CCHHS/ACHN	30.4%	28.9%	-4.9%	↓		
# Assigned MHN ACO ***NEW***	24,340	29,570	21.5%	↑		
% Total Members @ MHN ACO	28.1%	30.6%	8.8%	↑		
Referral Management						
# Authorizations: Inpatient	1,041	1,557	49.6%	↑		
# Authorizations: Outpatient	1,472	2,405	63.4%	↑		
Member Risk Stratification						
Total Outreached Members	25,606	30,776	20.2%	↑		
Health Risk Assessments/Screenings YTD	12,411	18,312	47.5%	↑		
YTD % High Risk Members	3.1%	4.6%	50.0%	↓	2.0%	1.1%
Utilization Management (7/1-12/31/2014)						
Admits/1,000	167					
Days/1,000	735	Data not yet available				
ED Visits/1,000	984					
% 30-day Readmissions	21%				14.7%	-14.700%
CCHHS Utilization (7/1-1-31/2015)						
Emergency Room	17.2%	17.1%	-0.7%	↓		
Hospital Inpatient	15.1%	15.2%	0.9%	↑		
Hospital Outpatient	25.7%	25.3%	-1.5%	↓		
Other Medical	0.61%	0.58%	-5.6%	↓		
Primary Care	40.1%	38.7%	-3.5%	↓		
Specialist	7.9%	7.6%	-3.7%	↓		

4) Operations

Key Measures	Dec'14	Jan'15	% Change From Month Prior	Trend	Target/ Comparison	% to Target/ Comparison
Operations						
Call Center					Goal	Goal Met
Call Volume	22,247	23,240	4.5%			
Abandonment rate	1.6%	5.4%	236.3%		<4%	N
Hold time	:01:04	:01:07			< :01:00	N
Average speed to answer	:00:14	:00:34			< :00:45	Y
Claims Processing					# Days	Goal Met
# Claims Paid	119,380	54,194				
# Claims Recv'd/DOS ***NEW***	87,483	78,783				
Avg # Days Received-to-Processed	6	3			< 8	Y
Avg # Days Received-to-Paid	25	25			< 35	Y

Call Center Performance Drivers	Aban %	Avg Hold Time
Goal	<4%	<1 MIN
Totals	**5.4%**	**0:01:07**
Mem Eng	5.9%	0:55
Mem ESP	4.0%	1:12
Provider	5.8%	0:59
Med Mgmt	5.9%	2:33
Eligiblity	3.2%	0:56
Claims	2.6%	0:51

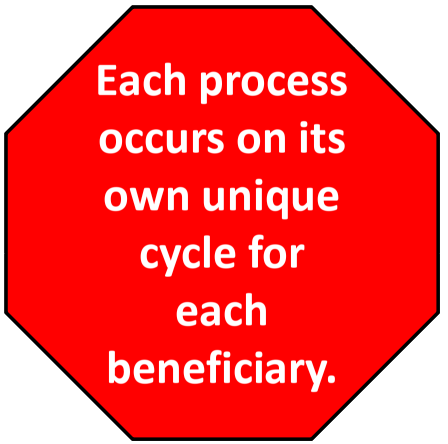
Choice & Redetermination

Health Plan Choice

- IL statute: 50% of Medicaid beneficiaries statewide in care coordination by Jan 1, 2015
- Voluntarily or auto-assignment
- Locked-in with “selected” plan until next cycle

Redetermination

- Federal requirement to demonstrate continued eligibility for benefits
- Cannot happen more than 1x/year
- IL Medicaid Redetermination Project (IMRP) for Medicaid & AllKids



Action Plan

Health Plan Choice

ACA Waiver
- Early entry into mandatory Medicaid market

PCP Network
- Favorable for auto-assignment
- CCHHS ACHN, FQHCs

Engaged Providers
- Identified CountyCare as "preferred" health plan for patients auto-assigning

Community Outreach & Marketing
- Continued community outreach and marketing campaign

Redetermination

Current Activities…
- Develop lists internally
- Call center outreach & inbound calls, and support with IMRP
- Notification mailings
- CCHHS & network provider education

Moving Forward…

Additional State Support
- HFS: Pilot Health Plan for new process of providing rede list
- DHS: Consolidation of redes to Hoyne Office

Member Campaign/Support
- "Keep Your Medicaid Benefits" campaign
- Multi-media approaches mirroring IMPR timeline: outbound and inbound calls; mailings; flags in Rx and registration; links on CCHHS & CountyCare patient portals and web sites

Engagement of Network Providers
- Distribute lists of members up for Rede received from State